

TYPE OR PRINT ALL INFORMATION NEATLY AND COMPLETELY IN APPROPRIATE SPACES

(PERF)

NCPPP UNIVERSAL CLAIM FORM (UCF)

(PERF)

CARDHOLDER I.D. _____ GROUP I.D. _____

CARDHOLDER NAME L/F/MI PLAN NAME _____

PATIENT NAME L/F/MI OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____

PATIENT DATE OF BIRTH MM DD CCYY PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____

PHARMACY NAME _____

ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____

CITY _____ PHONE NO. () _____

STATE & ZIP CODE _____ FAX NO. () _____

WORKERS COMP. INFORMATION

EMPLOYER NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

CARRIER I.D. (6) _____ EMPLOYER PHONE NO. _____

DATE OF INJURY MM DD CCYY CLAIM (7) REFERENCE I.D. _____

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.
PATIENT / AUTHORIZED REPRESENTATIVE _____

FOR OFFICE USE ONLY	

ATTENTION RECIPIENT
PLEASE READ
CERTIFICATION
STATEMENT ON
REVERSE SIDE

1

PREScription / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PREScriBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS CODE (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

2

PREScription / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL#	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PREScriBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS CODE (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)
A B C					

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

1

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

IMPORTANT I certify that the patient information entered on the front side of this form is correct, that the patient named is eligible for the benefits and that I have received the medication described. If this claim is for a workers compensation injury, the appropriate section on the front side has been completed. I hereby assign the provider pharmacy any payment due pursuant to this transaction and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to this claim to the plan administrator, underwriter, sponsor, policyholder and the employer.

PLEASE SIGN CERTIFICATION ON FRONT SIDE FOR PRESCRIPTION(S) RECEIVED

INSTRUCTIONS

1. Fill in all applicable areas on the front of this form.
2. Enter COMPOUND RX in the Product Service ID area(s) and list each ingredient, name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
3. Worker's Comp. Information is conditional. It should be completed only for a Workers Comp. Claim.
4. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
5. Limit 1 set of DUR/PPS codes per claim.

DEFINITIONS / VALUES

1. OTHER COVERAGE CODE

- | | | |
|--|--|---|
| 0=Not Specified | 1=No other coverage identified | 2=Other coverage exists-payment collected |
| 3=Other coverage exists-this claim not covered | 4=Other coverage exists-payment not collected | 5=Managed care plan denial |
| 6=Other coverage denied-not a participating provider | 7=Other coverage exists-not in effect at time of service | 8=Claim is billing for a copy |

2. PERSON CODE: Code assigned to a specific person within a family.

3. PATIENT GENDER CODE

- PATIENT GENDER CODE
0=Not Specified 1=Male 2=Female

4. PATIENT RELATIONSHIP CODE

- 0=Not Specified
3=Child
- 1=Cardholder
4=Other
- 2=Spouse

5. SERVICE PROVIDER ID QUALIFIER

- | | | |
|--|---------------------------------------|-------------------|
| Blank=Not Specified | 01=National Provider Identifier (NPI) | 02=Blue Cross |
| 03=Blue Shield | 04=Medicare | 05=Medicaid |
| 06=UPIN | 07=NCPDP Provider ID | 08=State License |
| 09=Champus | 10=Health Industry Number (HIN) | 11=Federal Tax ID |
| 12=Drug Enforcement Administration (DEA) | 13=State Issued | 14=Plan Specific |
| 99=Other | | |

6. CARRIER ID: Carrier code assigned in Worker's Compensation Program.

7. CLAIM/REFERENCE ID: Identifies the claim number assigned by Worker's Compensation Program.

8. PRESCRIPTION/SERVICE REFERENCE # QUALIFIER

- Blank=Not Specified 1=Rx billing 2=Service billing

9. QUANTITY DISPENSED: Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

10. PRODUCT/SERVICE ID QUALIFIER: Code qualifying the value in Product/Service ID (407-07)

- | | | |
|---|--|---|
| Blank=Not Specified | 00=Not Specified | 01=Universal Product Code (UPC) |
| 02=Health Related Item (HRI) | 03=National Drug Code (NDC) | 04=Universal Product Number (UPN) |
| 05=Department of Defense (DOD) | 06=Drug Use Review/Professional Pharm. Service (DUR/PPS) | 07=Common Procedure Terminology (CPT4) |
| 08=Common Procedure Terminology (CPT5) | 09=HCFA Common Procedural Coding System (HCPCS) | 10=Pharmacy Practice Activity Classification (PPAC) |
| 11=National Pharmaceutical Product Interface Code (NAPPI) | 12=International Article Numbering System (EAN) | 13=Drug Identification Number (DIN) |
| 99=Other | | |

11. PRIOR AUTHORIZATION TYPE CODE

- | | | |
|--|--|----------------------------|
| 0=Not Specified | 1=Prior authorization | 2=Medical Certification |
| 3=EPSDT (Early Periodic Screening Diagnosis Treatment) | 4=Exemption from copay | 5=Exemption from Rx limits |
| 6=Family Planning Indicator | 7=Aid to Families with Dependent Children (AFDC) | 8=Payee Defined Exemption |

12. PRESCRIBER ID QUALIFIER: Use service provider ID values.

13. DUR/PROFESSIONAL SERVICE CODES: Reason for Service, Professional Service Code, and Result of Service. For values refer to current NCPDP data dictionary.

- A=Reason for Service B=Professional Service Code C=Result of Service

14. BASIS OF COST DETERMINATION

- | | | |
|---------------------|---------------------------------|-------------------------------------|
| Blank=Not Specified | 00=Not Specified | 01=AWP (Average Wholesale Price) |
| 02=Local Wholesaler | 03=Direct | 04=EAC (Estimated Acquisition Cost) |
| 05=Acquisition | 06=MAC (Maximum Allowable Cost) | 07=Usual & Customary |
| 09=Other | | |

15. PROVIDER ID QUALIFIER

- | | | |
|---------------------------------|--|---------------------------------------|
| Blank=Not Specified | 01=Drug Enforcement Administration (DEA) | 02=State License |
| 03=Social Security Number (SSN) | 04=Name | 05=National Provider Identifier (NPI) |
| 06=Health Industry Number (HIN) | 07=State Issued | 99=Other |

16. DIAGNOSIS CODE QUALIFIER

- | B. SOURCE QUESTION | | |
|---|--|--|
| 01=Blank/Not Specified | 00=Not Specified | 01=International Classification of Diseases (ICD9) |
| 02=International Classification of Diseases (ICD10) | 03=National Criteria Care Institute (NDCC) | 04=Systemized Nomenclature of Human and Veterinary Medicine (SNOMED) |
| 05=Common Dental Term (CDT) | 06=Medi-Span Diagnosis Code | 07=American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders (DSM IV) |
| 09=Other | | |

17. OTHER PAYER ID QUALIFIER

- | | | |
|----------------------------------|---|---------------------------------|
| Blank=Not Specified | 01=National Payer ID | 02=Health Industry Number (HIN) |
| 03=Bank Information Number (BIN) | 04=National Association of Insurance Commissioners (NAIC) | 09=Coupon |
| 99=Other | | |

COMPOUND PRESCRIPTIONS - LIMIT 1 COMPOUND PRESCRIPTION PER CLAIM FORM.

[illegible]